STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265787	A. Building B. Wing	08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laverna Manor Health & Rehabilitation	904 Hall Avenue Savannah, MO 64485

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one cognitively impaired resident's (Resident #1) right to be free from abuse when staff found Resident #2 in Resident #1's bed with his hand on Resident #1's genital area. This deficient practice affected one of three residents sampled. The facility census was 78. The administrator was notified on 8/6/25 at 2:04 P.M. of an Immediate Jeopardy (IJ) which began on 7/31/25. The IJ was removed on 8/6/25 as confirmed by surveyor on-site verification.Review of the facility provided Policy Abuse Prevention Program, dated 2001 and revised 2011, showed:-Residents have the right to be free of abuse, neglect, misappropriation, and exploitation. This includes but is not limited to verbal, mental, sexual, or physical abuse; -As part of the resident abuse prevention, the administration will: protect residents from abuse by anyone including facility staff, other residents, consultants, and visitors;-Our facility will not condone any form of resident abuse or neglect;-Abuse is the willful infliction of injury, unreasonable confinement, or intimidation with resulting physical harm, pain, or mental anguish. 1.Review of Resident #1's Quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 7/15/25, showed: -Significant cognitive impairment, clear speech, usually understood, physical symptoms (such as hitting, kicking and pinching) directed at others 1-3 days of 7 days, and rejected care 1-3 days of 7 days, no wandering.-Diagnoses included: Dementia (a disease that affects the brain causing memory loss), without behavior disturbance, asthma, high blood pressure, psychosis (seeing /hearing and believing things that are not based in reality), anxiety, and Alzheimer's Disease. Review of the resident's Comprehensive Care Plan, dated 7/15/25, showed: -The resident had impaired cognitive function and/or impaired thought processes related to Alzheimer's Dementia;-She had difficulty making decisions, and had long and short term memory loss;-Staff should use the resident's preferred name, identify themself at each interaction, face the resident when speaking and make eye contact;-Reduce any distractions, such as turn off the television/radio, and close the door;-The resident understands consistent, simple, direct sentences. Provide the resident with necessary cues; stop and return if he/she became agitated;-Ask yes/no questions in order to determine the resident's needs. Cue, reorient and supervise as needed. Present just one thought, idea, question or command at a time.Review of the resident's July 2025 progress notes showed: -On 7/31/2025 at 6:07 A.M.: The night shift nurse called to report that a male resident had been found by the Certified Medication Technician (CMT) in Resident #1's room, lying in bed with her and his hand in Resident #1's pants, but outside of the brief. Resident #1 was not observed to be alarmed or in distress at the time. The residents were quickly separated and Resident #2 was removed from Resident #1's room and redirected. A physical exam of Resident #1 was immediately completed to ensure safety and no injury; with no signs of bruising, swelling or other sign of injury. The spouse and the doctor were to be notified this morning as well as other resident family and doctor. Staff were increasing monitoring for this resident to ensure safety and mental/emotional wellness;-7/31/2025 at 7:22 A.M.: It was reported from the previous shift, that a resident of the opposite sex was found in this resident's bed lying next to her. It was stated that Resident #2 had his hand down Resident #1's pants, moving it in a back & forth motion. It was reported the nurse on the previous shift examined Resident #1's bikini area and found no abrasions, bruising, or any other injuries. Resident #1 showed no distress/agitation. Resident #1 was very calm, resting quietly with eyes closed; -7/31/2025 at 10:41 A.M.: Resident #1's spouse notified of the incident;-7/31/2025 at 12:03 P.M.: Notified the resident's Primary Care Physician office nurse of incident.Review of Resident #2's Quarterly MDS, dated [DATE], showed: -Significant cognitive impairment, no behaviors, and partial/moderate assist of staff with Activities of Daily Living (ADLs: tasks completed in a day to care for oneself);-Diagnoses included: Respiratory failure, dementia with behavioral disturbance, high blood pressure, anxiety, bipolar disorder (a mental illness with significant shifts in mood, energy and function), and tremor. Review of the resident's Comprehensive Care Plan, dated 6/26/25, showed: -The resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to his/her cognitive deficits; -He wound wander around the unit, as he was disoriented to place, with impaired safety awareness; -Staff were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or books;-Provide structured activities such as toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. -The resident resided on the secure SCU; -The resident may become inappropriate, such as excessive groping/touching with other female residents/care staff. He will be monitored with no